

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-044623

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 179 Primary Registration District No. 5468 Registrar's No. 167

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED DEC 3 1963

1. PLACE OF DEATH a. COUNTY <u>Lincoln County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST. CHARLES</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>O'Fallon, Mo.</u> Length of stay in 1b		c. CITY OR TOWN <u>O'Fallon, Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wells Nursing Home</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>RR# 3. Flat Wood Road -</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>A.</u> Last <u>KERSTING</u>		4. DATE OF DEATH Month <u>11</u> Day <u>21</u> Year <u>62</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-22-1881</u> 9. AGE (last birthday) <u>82</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lincoln, County</u>	
11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ANTON KERSTING</u>		13b. MOTHER'S MAIDEN NAME <u>VICTORIA BENEDICT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>2</u>		16. SOCIAL SECURITY NO. <u>Frank Ebebeck</u>	
17. INFORMANT Address <u>O'Fallon, Mo.</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CORONARY ATHEROSCLEROSIS</u> DUE TO (c) <u>UNK</u>		INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>SEVERE RHEUMATOID ARTHRITIS</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of Item 18.)	
20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>11-1-63</u> to <u>11-21-63</u> and last saw him alive on <u>11-15-63</u> Death occurred at <u>5:00 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Paul Berryman</u>		22b. ADDRESS <u>Troy, Mo.</u>	
22c. DATE SIGNED <u>11-26-63</u>		23. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cemetery</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-23-63</u>	
23c. LOCATION (City, town, or county) (State) <u>St. Paul, Mo.</u>		23d. DATE RECD. BY LOCAL REG. <u>11-26-1963</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Gerry A. Davis O'Fallon, Mo.</u>		26. REGISTRAR'S SIGNATURE <u>Charlotti Leek</u>	

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

VS 300
Rev. 4/59

1 0570

2 0920

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12 86-0

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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Joseph B. Marshburn

Licensed Embalmer No. 5105

P. O. Address Troy, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.